



# Social protection systems

in **Latin America  
and the Caribbean**

## Uruguay

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# Social protection systems in Latin America and the Caribbean: Uruguay

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This document was prepared by Fernando Filgueira, Assistant Representative of the United Nations Population Fund (UNFPA) in Uruguay, and Diego Hernández, Associate Professor of the Department of Social and Political Science of the Catholic University of Uruguay. The document is part of the series of studies on "Social Protection Systems in Latin America and the Caribbean", edited by Simone Cecchini, Social Affairs Officer of Social Development Division of the Economic Commission for Latin America and the Caribbean (ECLAC), and Claudia Robles, consultant, with the same Division. Luna Gámez, consultant, provided editorial assistance. Valuable comments were received from Verónica Amarante.

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## Foreword

***Simone Cecchini***  
***Claudia Robles***

This report is part of a series of national case studies aimed at disseminating knowledge on the current status of social protection systems in Latin American and Caribbean countries, and at discussing their main challenges in terms of realizing of the economic and social rights of the population and achieving key development goals, such as combating poverty and hunger.

Given that, in 2011, 174 million Latin Americans were living in poverty —73 million of which in extreme poverty— and that the region continues being characterized by an extremely unequal income distribution (ECLAC, 2012), the case studies place particular emphasis on the inclusion of the poor and vulnerable population into social protection systems, as well as on the distributional impact of social protection policies.

Social protection has emerged in recent years as a key concept which seeks to integrate a variety of measures for building fairer and more inclusive societies, and guaranteeing a minimum standard of living for all. While social protection can be geared to meeting the specific needs of certain population groups —including people living in poverty or extreme poverty and highly vulnerable groups such as indigenous peoples—, it must be available to all citizens. In particular, social protection is seen a fundamental mechanism for contributing to the full realization of the economic and social rights of the population, which are laid out in a series of national and international legal instruments, such as the United Nations' 1948 Universal Declaration of Human Rights or the 1966 International Covenant on Economic, Social and Cultural Rights (ICESCR). These normative instruments recognize the rights to social security, labour, the protection of adequate standards of living for individuals and families, as well as the enjoyment of greater physical and mental health and education.

The responsibility of guaranteeing such rights lies primarily with the State, which has to play a leading role in social protection —for it to be seen as a right and not a privilege—, in collaboration with three other major stakeholders: families, the market and social and community organizations. Albeit with some differences due to their history and degree of economic development, many Latin American and Caribbean countries are at now the forefront of developing countries' efforts to establish these guarantees, by implementing various types of transfers, including conditional cash transfer programmes

and social pensions, and expanding health protection. One of the key challenges that the countries of the region face, however, is integrating the various initiatives within social protection systems capable of coordinating the different programmes and State institutions responsible for designing, financing, implementing, regulating, monitoring and evaluating programmes, with a view to achieving positive impacts on living conditions (Cecchini and Martínez, 2011).

Social protection is central to social policy but is distinctive in terms of the social problems it addresses. Consequently, it does not cover all the areas of social policy, but rather it is one of its components, together with sectoral policies —such as health, education or housing— and social promotion policies —such as training, labour intermediation, promotion of production, financing and technical assistance to micro— and small enterprises. While sectoral policies are concerned with the delivery of social services that aim at enhancing human development, and promotion policies with capacity building for the improvement of people’s autonomous income generation, social protection aims at providing a basic level of economic and social welfare to all members of society. In particular, social protection should ensure a level of welfare sufficient to maintain a minimum quality of life for people’s development; facilitate access to social services; and secure decent work (Cecchini and Martínez, 2011).

Accordingly, the national case studies characterize two major components of social protection systems –non-contributory (traditionally known as “social assistance”, which can include both universal and targeted measures) and contributory social protection (or “social security”). The case studies also discuss employment policies as well as social sectors such as education, health and housing, as their comprehension is needed to understand the challenges for people’s access to those sectors in each country.

Furthermore, the case studies include a brief overview of socio-economic and development trends, with a particular focus on poverty and inequality. At this regard, we wish to note that the statistics presented in the case studies —be they on poverty, inequality, employment or social expenditure— do not necessarily correspond to official data validated by the Economic Commission for Latin America and the Caribbean (ECLAC).

## I. Introduction: historical context for social protection policies<sup>1</sup>

Uruguay is a country with high human development, solid welfare standards and pioneer in social protection within Latin America. The Uruguayan social protection system has historically been based on four main pillars: education, health, social security and housing (Filgueira, 1994).

In the first place, public education has formed a key part of the Uruguayan society since the end of the 19<sup>th</sup> century, when an important level of investment was made in primary education infrastructure. Primary education reached universal coverage during the mid-20<sup>th</sup> century. Universal coverage in the first cycle of secondary education was also achieved between the 1980s and the 1990s. Mandatory education comprises today both primary and secondary education. The public education system gathers 80% of the total enrolment rate in the country. It provides non-confessional and free education from pre-school to higher education, including technical education.

In the second place, the first social security policies were also introduced by the end of the 19<sup>th</sup> century. This was a very fragmented system: insurance was first provided to some State workers, then coverage was extended to the whole public sector, and during the 1950s, to the remaining sectors. Also, during the 20<sup>th</sup> century, pension funds were created, providing special protection to particular groups of workers, such as workers from the financial sectors, notaries, university personnel, and most recently, the armed forces and the police. These institutions remain until today and are known as semi-public funds (*cajas paraestatales*).

Nevertheless, once it became universal, the social security system showed various weaknesses, in particular due to the lack of funding. Many reasons contributed to this: the Uruguayan population became increasingly old, some eligibility conditions became more flexible and benefits that were supposed to be contributive were delivered to constituencies which did not make contributions, as a way to maintain electoral support. Thus, since the mid-1970s the system went through parametric reforms, raising retirement age, among other measures. In parallel, benefits declined until it was decided by a popular plebiscite that social security payments should become indexed to the average wage. Finally, in 1996, a mixed system was implemented, combining both a pay-as-you-go and an individual capitalization pillar, and introducing private pension fund managers into the system.

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<sup>1</sup> This section is based upon Filgueira (1994) and Ferreira-Coimbra and Forteza (2004).



In the third place, the expansion of the health system during the early part of the 20<sup>th</sup> century was based on the development of both a public and a private health sector. The Ministry of Public Health (*Ministerio de Salud Pública*, MSP) was created in 1934. It manages and provides medical services under a highly centralised format. In parallel, private institutions such as the Collective Institutions for Medical Support (*Instituciones de Asistencia Médica Colectiva*, IAMCs) or the mutual societies were created since the end of the 19<sup>th</sup> and early 20<sup>th</sup> century. Both grant health services and integral health insurances.

During the 1980s and 1990s, a State subsidy allowing formal workers to affiliate to mutual societies was implemented. The institution managing the new health insurance was the Social Security Health Insurance Direction (*Dirección de Seguros Sociales por Enfermedad*, DISSE). However, in 2006, a reform to the system was introduced, creating the National Health Fund (FONASA) that replaced the DISSE, expanding the coverage of the health system, integrating the different sub-systems and combining various sources of funding.

Nowadays, the public healthcare network is managed by the State Health Services Administrator (*Administración de Servicios de Salud del Estado*, ASSE) that operates autonomously, while the MSP regulates healthcare institutions and attends matters of public health. On the other hand, the private system coexists with the public one and is non-for-profit. It is composed by the IAMCs and it is financed by private insurances and formal workers' contributions through FONASA.

Finally, housing policies have focused on the middle-income class, seeking to turn most of this population into owners. The most relevant housing institution used to be the Uruguayan Mortgage Bank (*Banco Hipotecario del Uruguay*, BHU) which provided housing loans and built properties. Since the end of the 1990s, this institution entered a crisis and became unsustainable due to the slowness of payments, among other reasons. Today, the BHU has a greater presence in the commercial property-sector; social housing projects are managed by the National Agency for Housing (*Agencia Nacional de Vivienda*), part of the Ministry of Housing (*Ministerio de Vivienda*).

## II. Main economic and social indicators

At the beginning of new millennium, Uruguay underwent a severe economic and financial crisis. GDP declined sharply between 2000 and 2003, although it has increased continuously since then (see figure 1). Accordingly, unemployment rates also increased during that period to an unprecedented level, to later decrease. Since 2006, the unemployment rate has remained below the level of 2000 (see figure 2).

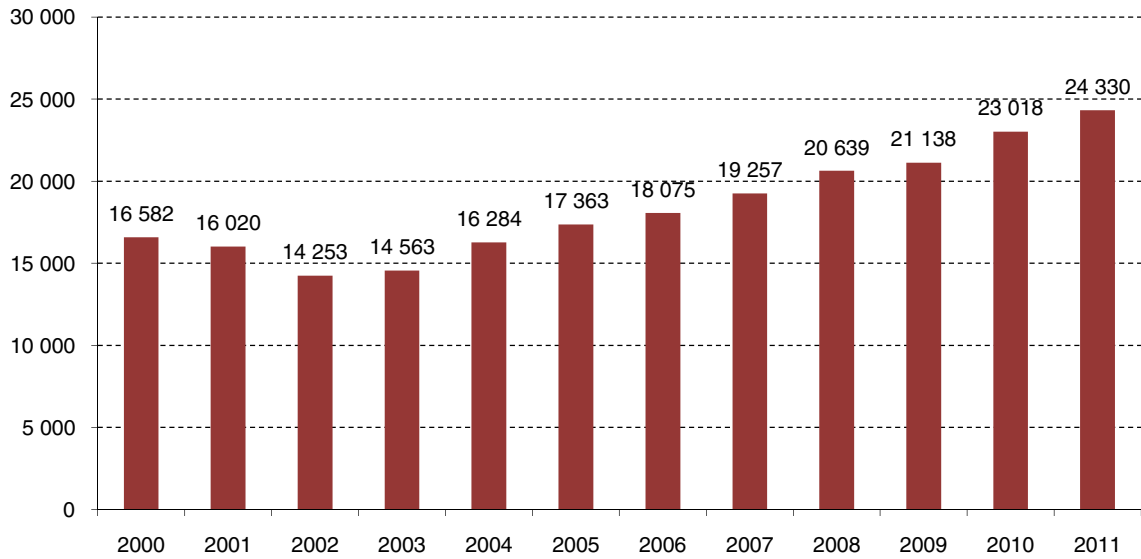
According to ECLAC data, poverty increased from 9.4% of the population in 1999 to 15.5% in 2002; however in 2011 the poverty rate reached 6.7%, a rate even lower than the pre-crisis level. Similarly, the Gini coefficient increased from 0.44 in 1999 to 0.46 in 2002, but declined to 0.40 in 2011, making Uruguay one of the least unequal countries of Latin America.

Thanks to the results of negotiations within the Council of Salaries (*Consejo de Salarios*), the minimum wage has also recovered, in line with the positive trends of unemployment rates and GDP. On the contrary, real wages only returned to the pre-crisis level in 2010, when they were only slightly higher than in 2000 (see figure 3).

The fiscal priority of social spending as a percentage of total public spending and as a percentage of GDP was also affected by the crisis of 2002/2003, although it later recovered. In 1998, public social spending as a percentage of total public spending was 67%; it declined to 57% in 2003, but in 2008 it had recovered beyond its initial level to 75%. As a percentage of GDP, social spending remained stable around 20-22%, although it increased by two percentage points since 2004 (MIDES, 2009), reflecting the expansive economic context of these years. Furthermore, in 2007, the growth rate of social spending surpassed that of GDP.

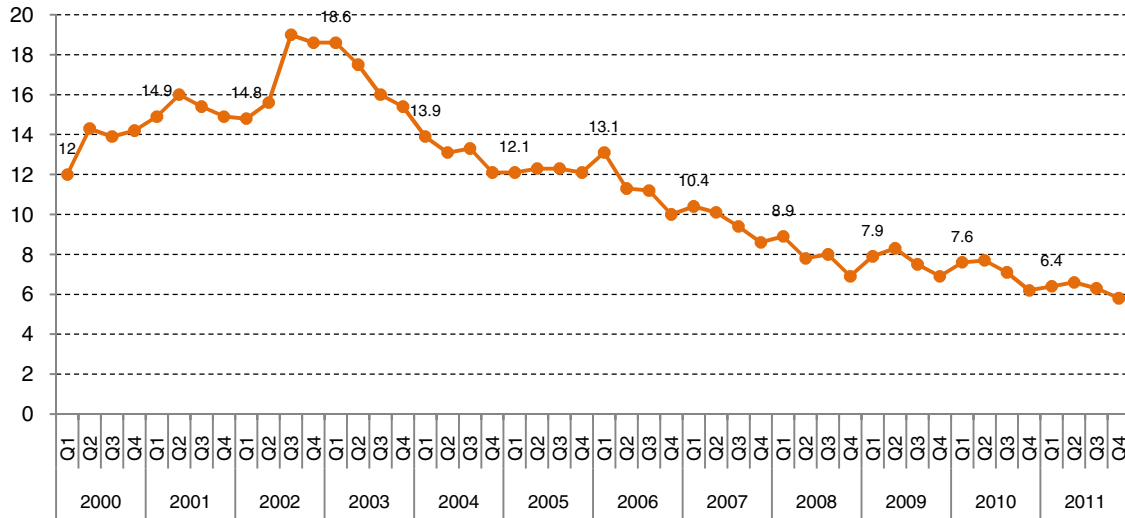
In Uruguay, more than half of public social spending is concentrated on social security and assistance. Since 2007, other sectors, such as health and —to a minor extent— education, have gained a greater relative incidence (see figure 4).

**FIGURE 1**  
**EVOLUTION OF GDP, 2000-2011**  
*(Million US\$ at constant market prices of 2005)*



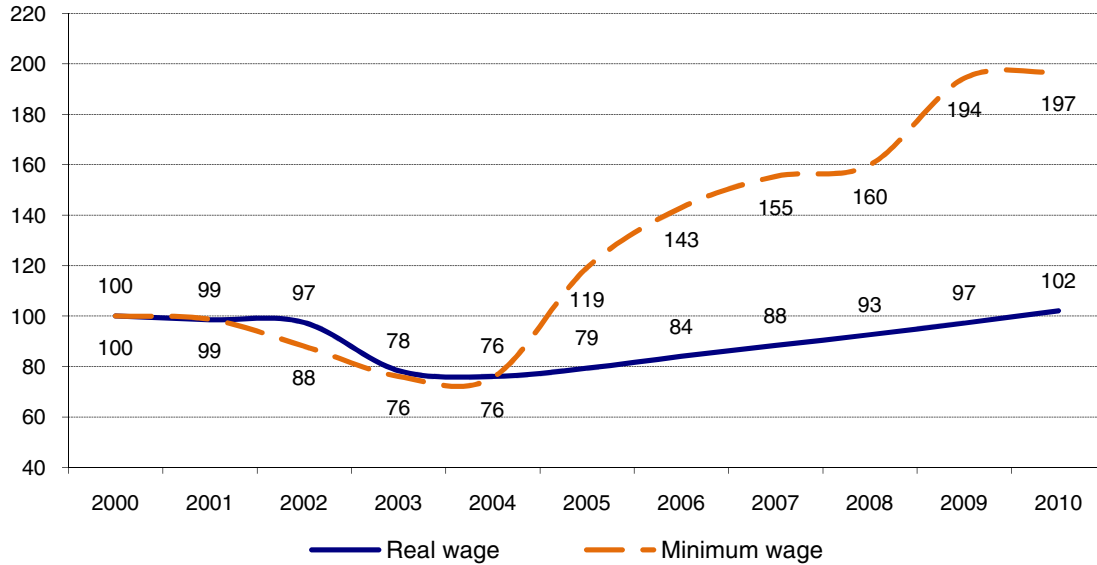
Source: Economic Commission for Latin America and the Caribbean (ECLAC): CEPALSTAT, Latin American Statistics.

**FIGURE 2**  
**UNEMPLOYMENT RATE IN AREAS WITH 5,000 OR MORE INHABITANTS,**  
**BY QUARTER, 2000-2011**  
*(Percentages)*



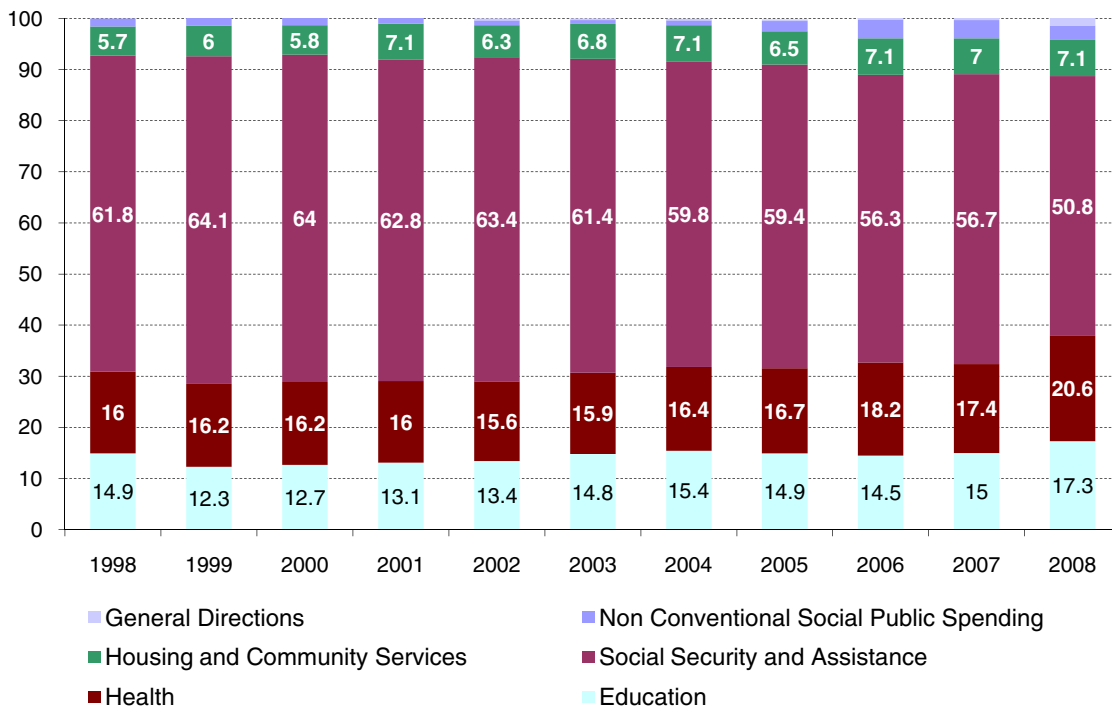
Source: Economic Commission for Latin America and the Caribbean (ECLAC): CEPALSTAT, Latin American Statistics.

**FIGURE 3**  
**MINIMUM WAGE AND REAL WAGES, 2000-2010**  
*(base year 2000 = 100)*



Source: National Statistics Institute.

**FIGURE 4**  
**PUBLIC SOCIAL SPENDING BY SECTOR, 1998-2008**  
*(Percentages)*



Source: MIDES (2009).



### III. Contributory social protection

Most of the spending on social security and assistance goes to the general regime for old age retirement, disability and survival pensions. To a large extent, this investment corresponds to State disbursements that seek to finance the persistent deficit caused by the difference between the contributions paid into the system and the expenditures paid out the system.

#### A. Overview of the pension system

Uruguay has a mixed pension system composed by two main pillars: a) a mandatory pay-as-you-go system based on intergenerational solidarity and financed via payroll taxes, other taxes and financial contributions made into the system by the central government; and b) an individual capitalization pillar. The latter requires that mandatory individual savings are made into personal accounts through direct contributions. The affiliation to this pillar is also compulsory but only for workers whose earnings are above a particular level. Voluntary contributions are also accepted, although in this case contributions are divided into equal parts and derived to both pillars. A third voluntary pillar is also available, but only for workers with higher earnings.

As part of the implementation of the individual capitalization accounts, private Pension Fund Managers (*Administradoras de Fondos de Ahorro Previsional*, AFAPs) were created. These institutions manage the pension funds and are responsible for their profitability, charging workers with a commission. Also, they are in charge of providing disability and survival pensions through insurance companies. Along with the AFAPs, an electronic system registering workers' history and contributions was introduced. This system sought to combat the delivery of pensions under irregular circumstances, avoiding *clientelism*. Yet, it also had adverse effects on the most vulnerable workers and those in the informal labour market that were unable to easily reconstruct their labour histories.

The pension system is financed through a combination of sources: employees contribute by 15% of their wages; employers, by 7.5% of the wages; and the State subsidises the debt of the Social Security Institute (*Banco de Previsión Social*, BPS). Public funds equate to a fifth of the total disbursements made by this institution due to the payment of pensions. Pensions paid through the individual capitalization accounts in the future are projected to be completely self-financed through the workers' contributions and the profitability of the funds.

Until 2008, access to contributive pensions required that workers had contributed for at least 35 years to the system and the minimum age at retirement was set at 60 years. After this date, years of contributions were reduced to 30. There is also a pension scheme for advanced old age workers who are over 70 years old and have not achieved the minimum requirements to retire. Under the new scheme, these persons should be 70 years old and have at least 15 years of contributions. For each year below the age threshold, the worker is required to have contributed two additional years to the system in order to get the benefit (for example, a worker aged 69 needs to have 17 years of contributions).

In the case of women, one extra year of contributions is added to their accounts per each son/daughter they had (with a maximum of five). Furthermore, the conditions to receive the disability pension —both the pension due to total disability ( *jubilación por incapacidad total*) or the transitory subsidy due to partial disability ( *subsidio transitorio por incapacidad parcial*) —, also became more flexible. For example, the prerequisite that workers should have worked during the six months immediately preceding a disability in order to receive the pension was eliminated.

Approximately 70% of all payments disbursed by the BPS correspond to the old age regime, disability and survival pensions, and 5% to family allowances. A further 15% covers the health insurance, and 2% corresponds to unemployment insurance.

## B. Unemployment insurance<sup>2</sup>

The unemployment insurance covers all formal workers who have been dismissed due to different reasons. It is financed through payroll taxes while at work. Between 1981 and 2008, the beneficiary workers of this insurance received a flat rate transfer for up to six months. This was equivalent to half of the average wage received during the six months previous to dismissal, which should not be inferior to half the minimum wage and superior to eight times the minimum wage.

Since the end of 2008, a reform was introduced to the system. This established a decreasing replacement rate —from 66% of the average wage during the first month up to 40% in the sixth month—. It was also established an additional six months coverage of this transfer for workers aged 50 years and above who are dismissed. The additional transfer for these workers is equivalent to the lowest amount received by regular workers during sixth months. Furthermore, this insurance is also extended for two months at times of economic crisis.

## C. Coverage of the pension system

The coverage of the pension system in Uruguay is very high. Eight in every ten persons aged 65 years old and above receive a pension, and this proportion does not change substantially along income quintiles. The exception is the lowest income quintile, which has a considerably lower proportion of older adults receiving a pension (see table 1).

The BPS is the main institution providing pensions in Uruguay, as it is shown in table 1. In the highest income quintiles, this institution loses representation in favour of the different semi-public funds. This is expectable since the BPS is the institution that provides the majority of non-contributory pensions. On the other hand, semi-public funds provide the best pension benefits and hence are more attractive for higher income workers.

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<sup>2</sup> This section is based on Casanova (2009).

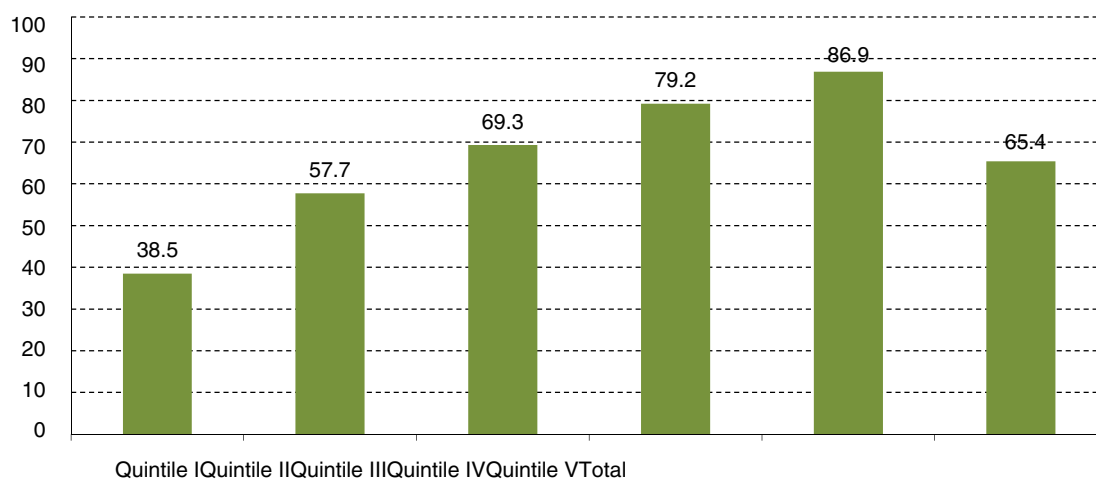
**TABLE 1**  
**PEOPLE AGED 65 YEARS AND ABOVE WHO RECEIVE ANY SORT OF PENSION**  
**BY SUB-SYSTEM OR INSTITUTION AND INCOME QUINTILE, 2007**  
*(Percentages)*

	Income quintile					Total
	1	2	3	4	5	
Does not receive a pension	27.3	15.6	14.1	13.2	13.6	15.3
Receive a pension	72.7	84.4	85.9	86.8	86.4	84.7
BPS	70.1	79.7	78.9	77.0	60.8	73.6
Military or police forces	2.6	4.1	5.8	6.6	6.5	5.5
Professional, notary or bank fund	0.0	0.05	0.5	1.9	15.8	4.2
Others	0.1	0.5	0.7	1.3	3.3	1.4
Total	100	100	100	100	100	100

Source: Continuous Household Survey (*Encuesta Continua de Hogares*), National Statistics Institute (INE).

The Uruguayan labour market has a high proportion of formal workers: almost two thirds of workers make contributions either to a fund, or to a greater extent, to the BPS. Becoming a formal worker assures health insurance for employees and their children, access to unemployment insurance in the case of private salaried workers, health attention in case of accidents at work and the right to a salary while on vacations, besides an old age income pension. The proportion of workers that contribute to a pension fund increases along income quintiles, showing a stratified distribution by income levels (see figure 5).

**FIGURE 5**  
**OCCUPIED THAT CONTRIBUTE TO A PENSION FUND**  
**BY INCOME QUINTILES, 2007**  
*(Percentages)*



Source: Continuous Household Survey (*Encuesta Continua de Hogares*), National Statistics Institute (INE).

Furthermore, between 2001 and 2008, the proportion of unemployed persons who received a partial income substitution was never superior to 15% (2008) and it was reduced to 6.5% between 2004 and 2005 at its lower point. This may be caused by the fact that many workers at the time of dismissal did not contribute to a pension fund or they did it for an insufficient period of time. This figure also provides an indication of the limits that the unemployment insurance still has in Uruguay.





## IV. Non-contributory social protection

Uruguay has a non-contributive disability and old age pension which was established in 1919. This scheme provides economic support to all persons who lack a monetary income to afford their livelihood expenses due to old age or disability. It consists of a transfer paid to people aged 70 and above or living with a disability who are under the poverty line—as demonstrated by proxy means tests—. The programme is operated by the BPS and the pensions are paid to Uruguayan citizens, foreigners who prove residency in the country for over 15 years, and Uruguayans living in Brazil and Argentina within five kilometres from the Uruguayan border.

In 2007, an old age assistance scheme was created for elders aged between 65 and 70 years old who are not enrolled in any pension scheme. When they are aged 70, they enter automatically the pension scheme in old age.<sup>3</sup>

In recent years, further transfers have been incorporated into the system. Initially, these were created in the context of the economic crisis to alleviate its social consequences—this was the case of the National Social Emergency Response Plan (PANES) (2005-2007) and the cash transfer related as part of this plan—. Later, more permanent transfers were designed as part of the Equity Plan. This has been the case of the Family Allowances (*Asignaciones Familiares*, AFAM).

The Family Allowances are the main conditional cash transfer (CCT) programme in Uruguay. As in the case of non-contributive pensions, Family Allowances are included within the BPS and paid to families by this institution. The beneficiaries are vulnerable households with young people and children aged less than 18 years old. Beneficiary households should be composed of two or more persons, who may or may not be relatives, living under the same roof as a family unity or resembling a family unity. Vulnerability is defined in accordance to housing, sanitation and environmental conditions, the household's composition, and the characteristics of its members, beyond solely considering income. These dimensions are combined into an income predictor algorithm (proxy means test) in order to determine the eligibility of the households for the programme. As with the case of other CCT programmes within Latin America, women are usually conceived as the administrators of the transfer within the families.

The beneficiaries of these Family Allowances are children falling under the following categories: a) since the confirmation of pregnancy until they are aged 14 years; b) until aged 16 years,

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<sup>3</sup> See [online] <http://dds.cepal.org/bdps/programa/componentes.php?id=51>.

if they have been unable to complete primary education due to justified reasons; c) until aged 18 years, if enrolled in higher education; and d) for life, in case of disability, requiring that permanent checkups are made every three years.

The transfers delivered by the programme are determined according to the number of beneficiaries in each household, the level of education in which children or young persons are enrolled and the disability of the beneficiaries. The base transfer for children attending primary school is UYU\$ 700 (approximately, US\$ 35) and for children attending secondary school is UYU\$ 1,000 (approximately, US\$ 50). In the case of children living with a disability, the transfer is a flat rate of UYU\$ 1,000.<sup>4</sup>

## **A. Sources of funding and coverage of the non-contributory programmes**

One of the peculiarities of the social protection system in Uruguay is that both contributive and non-contributive transfers are integrated, financed and provided under a single institution, the BPS.

Family Allowances, plus other family and maternity expenditures, correspond to approximately 5% of the payments disbursed by the BPS. During the first three months of 2009, 340,000 family allowances were distributed in Uruguay under the new system launched in January 2008, which gives more generous benefits. This is equivalent to little less than 40% of children aged 0 to 18 years old receiving this transfer. 170,000 persons still received the former allowance—equivalent to slightly less than a third of the new transfer—. Considering both transfers, it may be estimated that six in every ten children receive a family allowance. This figure is higher than the average of children living in poverty, indicating a very large coverage. Nevertheless, the average value of contributive pensions is more than the double of the value of non-contributive allowances provided by the BPS.<sup>5</sup>

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<sup>4</sup> Uruguayan pesos of 2008.

<sup>5</sup> Estimation for June 2008, in Uruguayan pesos of 2008, based on the data from the BPS.

## V. Health sector

The health sector in Uruguay comprises the public and private sector. The public health system provides services through the State Health Services Manager ( *Administración de Servicios de Salud del Estado*, ASSE). The private system is composed mostly by Collective Institutions for Medical Support (IAMCs) —or mutual societies ( *mutuales*)—. Although they differ in the waiting times for attention and in the quality of services, both provide an integral health insurance and access to all levels of medical attention.

### A. Overview of the health system

Public health services include a primary care network composed of local premises and regional or national hospitals. Some municipal governments provide public primary healthcare services and La República University also has a hospital of national reference. These institutions work co-ordinately and those who are affiliated to the system may access any of these services.

Free medical attention is guaranteed according to the socio-economic situation of the families: for families living in extreme poverty, the attention is totally free; low-income families must pay a tariff and co-pay some services, although these costs are considerably lower than those of the private sector.

Access to care services provided by the ASSE is also possible through social security and the National Health Fund (FONASA). FONASA provides healthcare insurance for formal workers and their children aged 18 years and below. Insured members may opt between the services provided by the IAMCs —that also provide integral healthcare services at all levels of attention— or the ASSE. In most cases, the affiliated members of FONASA choose the services provided by the IAMCs; however, there are also cases in which ASSE's services are selected, since the services provided by the IAMCs are more expensive or, in the case of small towns, there are only public services available.

With respect to the private health system, there are two ways to access the IAMCs. In the first place, it is possible to contract the insurance paying a monthly fee (approximately, of US\$ 60). This fee is complemented with low-cost copayments for general or specialised medical attention and medicines. In 2002, 75% of the private disbursement in healthcare corresponded to the payment

of insurances and only 25%, to out of pocket expenditures on healthcare. <sup>6</sup> The monthly fee is a flat rate, equal for all members. Thus, the system is built upon a strong redistributive logic among healthcare institutions that benefits the high-risk population, which receives a subsidy from healthier population.

In the second place, access to the IAMCs is also possible through social security or the FONASA. Under this scheme, each worker contributes to the system through payroll taxes. Both the workers and their children aged 18 years or below are entitled to access these services. Moreover, the State makes per capita monthly transfers to health institutions according to the risk profile of the insured worker. In 2007, 49% of the population affiliated to IAMCs were paid by DISSE—the equivalent to the current FONASA—. Nowadays, this figure is even higher due to the inclusion of public workers and people aged below 18 years old within FONASA.

The attention provided by the IAMCs is of a higher quality than that of the public system in terms of hospital infrastructure, number of health workers by attended population and waiting times. Yet, the attention received at the public system adjusts to reasonable levels. National indicators bear witness to this statement: the prevalence of infant mortality rate is one of the lowest within the region; there is 100% coverage of skilled attendance at delivery and 94% of children are immunised against measles, polio or other diseases (OMS, 2009).

## B. Sources of funding and coverage of the health system

The public health system is financed by both budgetary allocation and the contributions made by the affiliated members through social security. The IAMCs are financed by the monthly fees paid by individually affiliated members and per capita transfers received through social security. This money is collected by the State and consists of the contributions made by the workers (ranging between 3% and 6% of their wages, depending on the amounts of the salaries and if they have children) and their employers (5% of the wages). The FONASA also receives budgetary allocation to complement per capita costs.

Between 2005 and 2009, the budget for public healthcare increased by 87%, while the attended population decreased by 16%. Accordingly, per capita spending on public healthcare increased at a constant rate from UYU\$ 342 to UYU\$ 759 during this period, equivalent to an increase of 121% (Oddone, 2009).

The vast majority of the population in Uruguay has some type of health insurance, mostly concentrated in the public or the IAMCs. Almost nine in ten Uruguayans declare receiving attention in any of these two systems; each of them covers a similar percentage of persons. Furthermore, approximately 7% of the population is covered by the health system of the Armed Forces; the same occurs with the Police Forces. <sup>7</sup> The rest of the insured population falls under not for profit private insurances that provide total or partial coverage (see table 2).

It is quite likely that the population that is insured by IAMCs has increased due to the implementation of a health reform that seeks to create an Integrated National Health System ( *Sistema Nacional Integrado de Salud*). This system is financed by FONASA—also created with the reform—and implemented gradually. Initially, public workers and their children aged 18 years and below—that previously were not covered—, as well as the children of private workers aged 18 years and below, were incorporated into the system. Hence, many persons that under the former regime could not afford the attention of the IAMCs, acquired the right to be covered by these institutions.

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<sup>6</sup> Based on information from the World Health Report 2005. See also Perticará (2008).

<sup>7</sup> These are public institutions, but operate under the logic of mutual funds.

**TABLE 2**  
**HEALTH: MOST FREQUENT PLACE OF HEALTH ATTENDANCE**  
**BY INCOME QUINTILES, 2007**  
*(Percentages)*

	Income quintile					Total
	1	2	3	4	5	
Does not receive attention	2.2	2.6	2.5	2.0	1.0	2.1
Public health (MSP, BPS, Family Allowances)	80.7	51.0	28.2	12.3	2.6	42.4
IAMCs	12.0	32.6	54.5	73.8	81.6	44.2
Military or police forces health care institutions	3.3	9.7	9.6	7.0	4.3	6.6
Total coverage private insurances	0.0	0.0	0.2	1.0	7.5	1.3
Others	1.9	4.1	4.9	3.9	3.0	3.4
Total	100	100	100	100	100	100

Source: Continuous Household Survey (*Encuesta Continua de Hogares*), National Statistics Institute (INE).



## VI. Education sector

In Uruguay, education is a right and the mandatory minimum level of education comprises 13 years of study. Children enter the education system when they are aged 4 —getting into pre-school or initial education— until they complete secondary education at the age of 17 (theoretical age). For all levels, public and free services are available, in special throughout the mandatory cycle of education. Most of the institutions providing initial, primary, secondary (both technical and traditional) and teaching development education are administered by the National Public Education Administration (*Administración Nacional de Educación Pública*, ANEP). There is only one public higher education institution (Universidad de la República).<sup>8</sup> The private education sector has a very low coverage and has a greater presence in the levels where public education is weaker. This is the case of initial or pre-school education for children aged 0 to 2 years old. Also, “co-payments” in education exist—for books, transportation or in terms of the opportunity cost of not working—, especially for tertiary education, limiting the access to a part of the population.

### A. Coverage of the education system

The coverage of primary education in Uruguay is universal, both in terms of enrolment and completion and regardless of the socio-economic level of children (see figure 6). This is not the same than saying that all children complete this education level at the age they are expected: there are education lags between ages and levels attended by children.

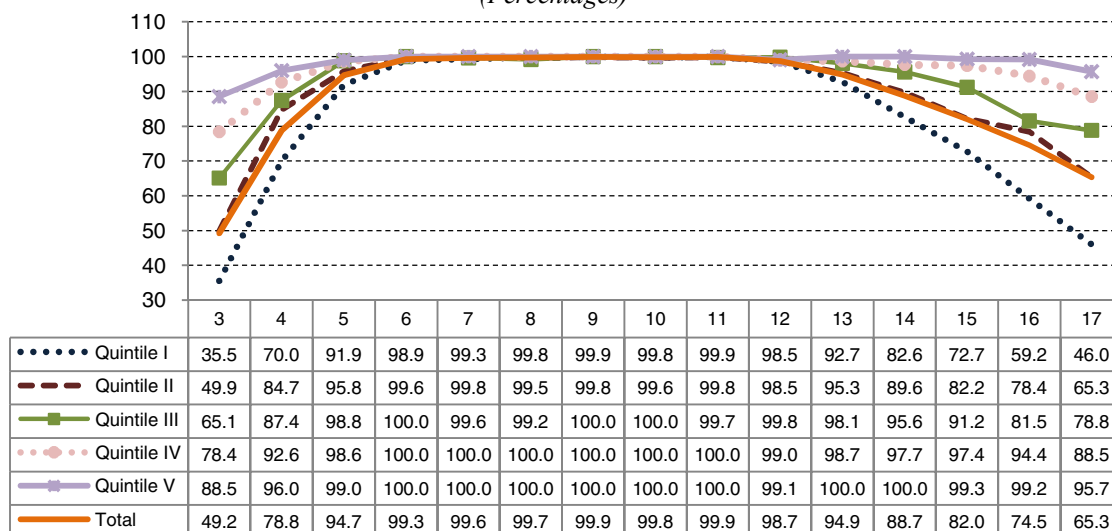
From the age of 13, attendance rates decline, affecting disproportionately the poorest children (see figure 6). Thus, the great majority of children are enrolled in the basic cycle of secondary education; however, a third does not complete this level. Also, two thirds of children do not complete secondary education. Furthermore, more than half of young persons aged 17 years old and belonging to the poorest quintile do not attend school at any level (MEC, 2008). This is an indication of a highly regressive distribution of the system’s results (in terms of school completion).

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<sup>8</sup> For a thorough description of the educative sector, see MEC (2009) and [online]: < [www.anep.edu.uy](http://www.anep.edu.uy)>.



**FIGURE 6**  
**ATTENDANCE TO ANY EDUCATION INSTITUTION BY SIMPLE AGE**  
**AND INCOME QUINTILE, 2007**  
*(Percentages)*



Source: Continuous Household Survey (*Encuesta Continua de Hogares*), National Statistics Institute (INE), 2007.

The public system of education covers most students. With the sole exception of pre-school between the age of 0 and 2 years old, the rest of the education levels have a public school enrolment rate of 85% or above. Also, most children enrolled in private schools belong to the highest income quintile and live in the capital city of the country (see table 3).

**TABLE 3**  
**DISTRIBUTION OF THE ENROLMENT RATE AMONG PUBLIC**  
**AND PRIVATE INSTITUTIONS, 2007**  
*(Percentages)*

	Public	Private	Total
Initial	67.5	32.5	100
Primary	85.4	14.6	100
Basic cycle of secondary education	85.1	14.9	100
Second cycle of secondary education	86.1	13.9	100
Higher education	85.0	15.0	100

Source: Ministry of Education and Culture, (MEC) (2008).

The regressivity of the completion rates for students belonging to different income quintiles is further reinforced by the fact that poorest students are also the ones obtaining the worst results in the educative process.<sup>9</sup> In the case of primary education, this is independent from the enrolment at a private or a public institution; in fact, the stratification of students' results persists within the public system. Various measures have been recently implemented to reverse this trend, such as implementing the full day school for the most vulnerable children and the Community Teachers programme (*Maestros Comunitarios*) that seeks to reinforce the work with the children and their families. In the case of the secondary education, this stratification persists, although the gaps in the results obtained by private and public institutions become more evident, as it has been shown by the Programme for International Student Assessment (PISA) test.

<sup>9</sup> See ANEP (2005).

## VII. Other sectors

Historically, housing policies were focused on the middle class and they sought to consolidate home ownership among these groups. Consequently, there are a large percentage of house owners in Uruguay. Currently, these policies have become re-oriented to social housing programmes.

In 2005, the National Agency for Housing ( *Agencia Nacional de Vivienda*) was created as part of the Ministry for Housing, Territorial Planning and the Environment ( *Ministerio de Vivienda, Ordenamiento Territorial y Medio Ambiente*, MVOTMA). This agency —through the National Fund for Housing ( *Fondo Nacional de Vivienda*)— aims to implement a housing policy to allow access to social housing by middle- and low-income groups . Also, changes in the regulation of the Uruguayan Mortgage Bank (BHU) were pursued in order to convert it into a public mortgage bank that could compete with private banking.

Furthermore, since 1967, the Movement for the eradication of the insalubrious housing ( *Movimiento para la Erradicación de la Vivienda Rural Insalubre*, MEVIR) a non-State public organization, builds rural housing and improves the environment for rural workers. The boost experienced by irregular settlements in the country has been dealt with the creation of a programme financed by an external loan to regularize and improve irregular housing settlements —the Irregular Settlements Integration Programme ( *Programa de Integración de Asentamientos Irregulares*).

Concerning basic services and food programmes, no exhaustive research has been made. These intervene both in the municipal and national level. The State provision of basic services —water, electricity and telephones—, acts as a moderator effect to prevent tariffs from rising. This also allows the State to keep some social control over otherwise heavily commodified services.

Finally, it is important to underline the existence of various municipal subsidies to transport. Various governmental departments have one. In Montevideo, for example, municipal authorities estimate in 20% the reduction in the transport tariff due to this subsidy. There are also specific subsidies that reduce in up to 50% the value of the common tariff to students and pensioners.



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This report is part of a series of national case studies aimed at disseminating knowledge on the current status of social protection systems in Latin American and Caribbean countries, and at discussing their main challenges in terms of realizing the economic and social rights of the population and achieving key development goals, such as combating poverty and hunger.

Social protection has emerged in recent years as a key concept which seeks to integrate a variety of measures for building fairer and more inclusive societies, and guaranteeing a minimum standard of living for all. In particular, social protection is seen a fundamental mechanism for contributing to the full realization of the economic and social rights of the population—to social security, labour, the protection of adequate standards of living for individuals and families, as well as the enjoyment of greater physical and mental health and education.

Albeit with some differences due to their history and degree of economic development, many Latin American and Caribbean countries are at now the forefront of efforts to establish these guarantees by implementing various types of transfers, including conditional cash transfer programmes and social pensions, and expanding health protection. One of the key challenges that the countries of the region face, however, is integrating the various initiatives within social protection systems capable of coordinating the different programmes and State institutions responsible for designing, financing, implementing, regulating, monitoring and evaluating programmes, with a view to achieving positive impacts on living conditions.



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